Medicare Financing and Prescription Drugs

Joseph R. Antos

Resident Scholar, American Enterprise Institute

and

Adjunct Professor, School of Public Health
University of North Carolina, Chapel Hill

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American Enterprise Institute
1150 17th Street, N.W.
Washington, D.C. 20036
(202) 862-5938
jantos@aei.org

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Mr. Chairman and members of the Committee, thank you for inviting me to testify today. My name is Joseph Antos. I am a resident scholar at the American Enterprise Institute for Public Policy Research in Washington, where I concentrate on health economics. I am also an adjunct professor at the University of North Carolina, Chapel Hill, School of Public Health. Previously I was the assistant director for health and human resources at the Congressional Budget Office, where much of my work addressed the challenges facing the Medicare program.

My testimony will focus on the need to modernize and reform Medicare. The program enjoys broad popularity for its success in making high quality medical care affordable for seniors. But Medicare is also widely criticized for offering inadequate benefits, being unresponsive to the concerns of health care providers regarding both payment for services and administrative complexity, and rapidly rising program costs. Congress is considering actions that could improve Medicare in some of those dimensions. The decisions that are made this year–particularly decisions on a prescription drug benefit–could have a significant impact on the long-term viability of the program.

Challenges Facing Medicare

The financial challenges facing Medicare are well known, and were recently re-emphasized by the annual report of the Medicare trustees. The program will spend $250 billion this year for hospital, physician, and other health services provided to 40 million elderly and disabled Americans. Over the next decade, Medicare spending is expected to grow about 7 percent a year, outstripping growth in the economy and in federal revenues. That projection does not reflect increases in provider payments that may be enacted this year, nor does it include the cost of a Medicare prescription drug benefit.

The long-term outlook for Medicare financing is driven by demographics and the increasing use of health services among Medicare beneficiaries. By 2030, about 78 million people will be enrolled in the program when most baby boomers will have become eligible for Medicare, and as longevity continues to increase. At the same time, the working age population will grow more slowly, resulting in a drop in the ratio of workers to beneficiaries. Thus Medicare spending will rise more rapidly than the resources available to finance it.

According to the Medicare trustees, program spending will climb from 2.3

percent of GDP in 2000 to 4.5 percent of GDP in 2030 (see figure 1). In today's dollars, each percentage point of GDP is equal to about $100 billion. Medicare's budgetary impact in 2030 would be roughly equivalent to additional program spending of about $200 billion in 2002.

The rapid growth in program spending will not be matched by a similar growth in revenues that are specifically dedicated to Medicare. Those dedicated revenues consist of payroll taxes, taxes on Social Security benefits, and premiums paid by beneficiaries. According to the Medicare trustees, the discrepancy between total Medicare expenditures and dedicated revenues was 0.5 percent of GDP in 2000. By 2030, the gap is projected to rise to 2.4 percent of GDP. The funding gap is currently made up through transfers from general revenues; such transfers will rise sharply over the next few decades unless significant changes are made to the structure of Medicare.

Other developments have given strong impetus to Medicare reform. The public has grown increasingly vocal about the inadequacies of Medicare's benefits, which reflect what a reasonable health insurance policy covered in 1965. Unlike most comprehensive insurance products available today, Medicare does not cover outpatient prescription drugs and provides no protection against very large medical costs. Many beneficiaries find that they have less health insurance coverage once they reach 65 than when they were covered by a health plan at work.

Beneficiaries often purchase supplemental private insurance to fill in some of the gaps in Medicare coverage, and to reduce the uncertainty they have about paying their share of the cost of Medicare-covered services. Such coverage can be a significant financial burden, however, costing thousands of dollars in annual premiums. Some beneficiaries find a low-cost alternative to Medigap by enrolling in a Medicare+Choice plan. But many health plans have dropped out of Medicare+Choice in recent years, and the remaining plans have pared back their benefits.

The provider community has become outspoken about the perceived inadequacy of Medicare payment. Physician payment rates were cut 5.4 percent in 2002, and are expected to drop a total of 18.2 percent by 2005. That has spurred a backlash from the physician community, with the possibility that seniors in some locales could have difficulty finding a doctor. Payment add-ons for skilled nursing facilities are scheduled to expire over the next six months, and the 15 percent

reduction in home health payments that Congress has delayed for several years is scheduled to take effect in October. Those payment changes have raised concerns about access to appropriate care for seniors, although there is little evidence thus far to suggest that access has become a significant problem.

Providers have been vocal about what they see as the unnecessary complexity and inflexibility of Medicare administration. According to a recent study by the General Accounting Office (GAO), for example, Medicare contractors provide information to physicians that is often difficult to use, out of date, inaccurate, and incomplete.[1] The carriers provide telephone and web-based information to physicians, but only 15 percent of the test questions fielded by GAO were answered completely and accurately. The Centers for Medicare and Medicaid Services (CMS) was criticized for failing to provide sufficient performance standards or oversight for contractors.

Medicare+Choice plans also have experienced payment and administrative difficulties that have contributed to the exodus of health plans from the program in the past several years. Because of payment formulas intended to reduce the geographic variation in payments to health plans and encourage plans to expand into underserved markets, most Medicare+Choice plans received 2 percent annual increases in their payment rates since 1999 even though their costs were rising 8 percent a year or more. In addition, uncertainty about future payment policy changes and a heavy regulatory burden has made Medicare+Choice an unattractive market for many health plans.

Risks of Piecemeal Policy Changes

The problems facing Medicare seem to have mushroomed in the past few years, but they reflect defects and rigidities in the design of the program that have persisted since 1965. Changing the Medicare benefit package literally requires an act of Congress. Consequently, Medicare has not kept up with rapid advances in medical care. Medicare payment rates often do not reflect conditions facing providers and health plans in their local markets, and rate setting mechanisms are slow to adapt to new economic realities. The formal regulatory process is complex, and the proliferation of manual instructions and other guidance in the

1. *Medicare Communications with Physicians Can Be Improved*, General Accounting Office, GAO-02-249, February 2002.

shadow regulatory process–meant to clarify how the regulations should apply in specific real-world circumstances–often lead to errors, uncertainty, and mistrust.

Restructuring Medicare to give beneficiaries realistic choices among competing health plans, similar to the way the Federal Employees Health Benefit Program (FEHBP) operates, could alleviate many of the problems in the current system. Such an approach could provide more meaningful health plan choices to beneficiaries than are now available under Medicare+Choice, with safeguards to assure reliability and high quality. Micromanagement and formula-driven payment rates could be replaced by a flexible approach to administration based on negotiation and market information.

A competitive strategy, even one based on an operating model such as FEHBP, must be developed carefully. The Administration has indicated an intention to present such a plan in the future. Until then, Congress is likely to take other steps to address some of the most important deficiencies of the current Medicare program. A risk of that approach is that some policy actions could hinder subsequent restructuring efforts, or at least forego an opportunity to foster reform.

The Medicare prescription drug benefit is a case in point. Adding a stand-alone drug benefit could retard progress on broader reform and reduce the program's financial viability in the long term unless other program changes also were made to improve incentives in the program. A drug benefit ideally would be part of the broader reform, and the benefit would be part of an integrated package of benefits provided by health plans participating in the Medicare program.

To illustrate the possible long-run impact of a stand-alone drug benefit, I estimated how much Medicare costs and revenues might increase over the next 30 years under the Clinton prescription drug proposal (see figure 2). The benefits under the proposal are fairly generous: no deductible, 50 percent coinsurance for the first $2,000 of spending, and stop-loss above $5,000 of total spending. According to the latest estimate from the Congressional Budget Office (CBO), the Clinton proposal would increase federal spending by $512 billion between 2005 and 2012. Premiums would be $29.50 a month in 2005.

In 2010, CBO estimates that the proposal would increase Medicare spending by $100 billion, or about 0.6 percent of GDP. Premium revenue would

equal $24 billion in that year, or less than 0.2 percent of GDP. Even with a generous drug benefit, the near-term impact on Medicare finances is quite modest, widening the gap between total program spending and dedicated revenues by 0.4 percent of GDP.

By 2030, however, the cost of the drug benefit could grow dramatically. I assumed that per capita drug spending would grow at a constant 10 percent a year.[2] Under that assumption, total Medicare spending would jump to 6.6 percent of GDP in 2030. That is roughly equivalent to increasing the size of today's Medicare program by an additional $400 billion–larger than the budget for all non-defense discretionary programs combined.

Premiums from the drug benefit would grow more slowly, increasing Medicare revenue by about 0.4 percent of GDP. As a result, Medicare's financing gap would increase to about 4.1 percent of GDP in 2030–nearly doubling the draw on general revenues that was projected by the Medicare trustees.

This calculation demonstrates the potential financial consequences of adding a generous but underfunded benefit to Medicare without additional reforms. The actual impact of adding such a benefit depends on the specific design of the proposal and on other factors that cannot be foreseen with any accuracy, including the future path of pharmaceutical innovation, the impact of drug coverage on the use of other health care services, and changes in the incidence of specific diseases among the Medicare population. Those factors might reduce the long-run fiscal impact of a drug benefit–but they might also increase that impact.

Drug Benefit as a Step to Reform

Medicare reform will probably not be accomplished in one sweeping action. As we have seen with other attempts to reform the health system, it is difficult to obtain consensus from health policy experts on the best approach to reform. It may be even more difficult to convince the public that a massive change in the way they obtain health care will (eventually) be good for them. Moreover, we cannot

2. That is broadly consistent with projections from National Health Expenditures, which assume that total drug spending for the nation as a whole would grow an average of 10.3 percent a year between 2008 and 2011.

foresee all of the developments and reactions that might occur in response to major system change.

Phasing in reform can provide information about market reactions and allows mid-course corrections. A reform plan that has flexibility to accommodate to changing circumstances in the health care market has a greater chance of success than one that attempts to resolve every problem at the outset. A carefully designed prescription drug benefit could provide an opportunity to test market-based approaches to Medicare reform.

There are clear risks associated with a stand-alone prescription drug benefit. But there are policy options that could minimize those risks, and might also serve as a transition to broader reform. One approach, called the Prescription Drug Security (PDS) Card program, combines a drug discount card with insurance protection from high-end drug expenses. Low-income Medicare beneficiaries would be eligible for an annual cash subsidy–perhaps as much as $600–toward the cost of their first-dollar drug expenditures. Their premiums for catastrophic drug coverage would also be subsidized. Higher-income beneficiaries would not receive a subsidy. They would be able to contribute to their own prescription drug cash account on a tax-deductible basis and participate in catastrophic drug insurance. They would also receive any discounts for pharmaceutical purchases that are available from their plan.

The PDS card account would work like a debit card, allowing beneficiaries to draw down their deposit when they make prescription purchases. The account could be augmented with contributions from relatives, religious organizations, or other charitable groups. Beneficiaries would be able to keep any unspent funds in their accounts for health expenses in subsequent years.

Such a program would allow Medicare beneficiaries to select from a number of competing plans that offer drug coverage. Plans would have the flexibility to offer a variety of benefit and premium options. The program would target assistance to the most needy, i.e., low-income beneficiaries without other drug coverage. By providing a fixed subsidy rather than an open entitlement to benefits, the program gives enrollees an incentive to shop wisely.

Unlike a traditional Medicare benefit, administration of the PDS card program would be modeled after FEHBP. The administering agency would

provide broad direction on required benefits and other policies, negotiate premium offers with plans, and provide information to Medicare beneficiaries on their options and the performance of individual plans.

A prescription drug program of this sort could be a laboratory for development of broader Medicare reform. Unlike a pure discount card approach, it would provide a subsidy for low-income beneficiaries and true insurance protection against unforeseeable, large drug costs. Such a program would create an administrative infrastructure that is flexible and consumer-focused. Since it would initially be a stand-alone benefit, a competitive drug program could be implemented without having to resolve some difficult issues that are at the heart of proposals to restructure Medicare. Nonetheless, lessons from a competitive drug program could fruitfully be applied to the larger reform.

Conclusion

The Medicare trustees have once again reminded us that the Medicare program is on an unsustainable trajectory. Decisions made by Congress this year will have consequences well beyond the 10-year budget window. There is an opportunity this year to provide some needed help to Medicare beneficiaries through a prescription drug benefit, but there is the risk that such a benefit could increase long-run fiscal pressures and retard progress on the broader reform that is needed. A well-designed prescription drug plan, however, could be a step toward that reform.